Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

G. PETER FOOX, M.D.
P.O. BOX 8795
TYLER, TX 75701

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-1574-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am submitting the attached DWC-60 appeal as it is apparent that the carrier in question is not in compliance with the Fee Guides for this service. Their claim that the level of service does not support the fee is wrong. It does not depend on whether an impairment is actually assigned. It is erroneous of them to state if 0% is calculated that the injury was trivial and only the narrative portion of IR/MMI is to be paid. I did the exact same level of service to calculate this impairment as I would if there was a specific impairment. Further more, 0% is actually an impairment rating."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance Company reviewed the requestor's TWCC-60 packet and has concluded to pay the disputed service."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2010	99456-WP	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation

Specific Services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 12, 2011 (2 EOB's)

- CAC-W1- Workers Compensation State Fee Schedule Adjustment.
- CAC-16- Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- CAC-18-Duplicate Claim/Service.
- 224-Duplicate Charge.
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892-Denied in accordance with DWC rules and/or Medical Fee Guideline.
- 742-Rule 134.202 MMI reached with no permanent I/R for sufficiently minor injury-only MMI portion of the exam shall be billed & reimbursed)

Explanation of benefits dated January 12, 2011

- CAC-W1- Workers Compensation State Fee Schedule Adjustment
- 920-Reimbursement is being allowed based upon a dispute.

Issues

1. Did the requestor receive payment for disputed service in accordance with 28 Texas Administrative Code §134.204?
2. Is the Requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds that on January 12, 2011 the Respondent audited the disputed services and issued payment to the Requestor in the amount of $350.00. The MAR for CPT code 99456-WP is $650.00. The Requestor was unsatisfied with the payment received therefore, filed a Request for Medical Fee Dispute Resolution received by the Division on January 20, 2011. On February 10, 2011 the Respondent's response to the dispute, stated that they concluded to pay for the disputed service. The Respondent submitted a copy of check #10622094 dated February 14, 2011 allowing an additional payment for the disputed amount of $300.00 for the disputed service.
2. The Division concludes that the Requestor has received payment for the disputed service in accordance with 28 Texas Administrative Code §134.204(b) & (g). Therefore, no additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 15, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee**

Dispute Resolution Findings and Decision together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.